

MEDICATION ALLERGIES: _____

OTHER ALLERGIES: _____

PAST MEDICAL HISTORY – Do you have or have you ever had the following:

	Yes	No		Yes	No
Measles	___	___	GERD (reflux)	___	___
Mumps	___	___	Hiatal Hernia	___	___
Whooping Cough	___	___	Anemia(type)	___	___
Scarlet Fever	___	___	Kidney Disease	___	___
Rheumatic Fever	___	___	Ulcer	___	___
Poliomyelitis	___	___	Hypothyroidism	___	___
Tuberculosis	___	___	Osteoarthritis	___	___
Pneumonia	___	___	Rheumatoid Arthritis	___	___
Asthma	___	___	Cataracts	___	___
Bronchitis	___	___	Glaucoma	___	___
Emphysema	___	___	Hepatitis	___	___
Hay fever/Sinusitis	___	___	Cancer	___	___
Hypertension	___	___	Type of Cancer	_____	
Coronary Disease	___	___	Other:	_____	
Diabetes (type)	___	___		_____	

SURGERIES – Please list type of surgery and your age at time of surgery:

FAMILY HISTORY:

Father: If Living Age and Health status: _____

 If Deceased Age at death and cause of death: _____

Mother: If Living Age and Health Status: _____

 If Deceased Age at death and cause of death: _____

